**U.S. Department of Labor**

Office of Administrative Law Judges
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**Issue Date: 04 November 2005**

Case No. 2003-BLA-6528

In the Matter of:
MONROE LEE WEST,
Claimant,

v.

CLINCHFIELD COAL CO.,
c/o ACORDIA EMPLOYERS SERVICE,
Employer,
and
SELF-INSURED THROUGH:
THE PITTSTON CO.,
COMPENSATION,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS'
COMPENSATION PROGRAMS,
Party in interest .

APPEARANCES:
Ron Carson, Lay representative
On behalf of Claimant

Lois A. Kitts, Esq.
On behalf of Employer/Carrier

BEFORE: Thomas F. Phalen, Jr.
Administrative Law Judge

## DECISION AND ORDER – DENIAL OF BENEFITS

This is a decision and order arising out of a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended by the Black Lung Benefits Act of 1977, 30 U.S.C. §§ 901-962, ("the Act") and the regulations thereunder, located in Title 20 of

the Code of Federal Regulations. Regulation section numbers mentioned in this Decision and Order refer to sections of that Title.[1]

On August 19, 2003, this case was referred to the Office of Administrative Law Judges by the Director, Office of Workers' Compensation Programs, for a hearing. (DX 45).[2] A formal hearing on this matter was conducted on January 5, 2005, in Harlan, Kentucky by the undersigned Administrative Law Judge. All parties were afforded the opportunity to call and to examine and cross examine witnesses, and to present evidence, as provided in the Act and the above referenced regulations.

## ISSUES[3]

The issues in this case are:

1. Whether the claim was timely filed;

2. Whether the Claimant has pneumoconiosis as defined by the Act and the regulations;

2. Whether the Claimant's pneumoconiosis arose out of coal mine employment;

3. Whether the Claimant is totally disabled;

4. Whether the Claimant's disability is due to pneumoconiosis;

5. Whether the Claimant has 2 dependents for purpose of augmentation; and

6. Whether the Claimant has established a material change in conditions under §725.309(c), (d).

(DX 45).

[1] The Department of Labor amended the regulations implementing the Federal Coal Mine Health and Safety Act of 1969, as amended. These regulations became effective on January 19, 2001, and are found at 65 Fed. Reg. 80, 045-80,107 (2000)(to be codified at 20 C.F.R. Parts 718, 722, 725 and 726). On August 9, 2001, the United States District Court for the District of Columbia issued a Memorandum and Order upholding the validity of the new regulations. All citations to the regulations, unless otherwise noted, refer to the amended regulations.

[2] In this Decision, "DX" refers to the Director's Exhibits, "EX" refers to the Employer's Exhibits, "CX" refers to the Claimant's Exhibits, and "Tr." refers to the official transcript of this proceeding.

[3] At the hearing, Employer withdrew as uncontested the following issues: Whether Claimant was a miner; whether the named employer is the responsible operator; whether the named employer has secured the payment of benefits; and whether the miner's most recent period of cumulative employment of not less than one year was with the named responsible operator. (Tr. 19). Additionally, Employer listed other issues that will not be decided by the undersigned; however, they are preserved for appeal. (DX 45, Item 18). Finally, the parties stipulated that Claimant worked at least 20 years in or around one or more coal mines. (Tr. 19-20).

Based upon a thorough analysis of the entire record in this case, with due consideration accorded to the arguments of the parties, applicable statutory provisions, regulations, and relevant case law, I hereby make the following:

## FINDINGS OF FACT AND CONCLUSIONS OF LAW

Background

Monroe West ("Claimant") was born on April 26, 1925; he was 79 years-old at the time of the hearing. (DX 4; Tr. 24). By letter dated July 11, 2005, the undersigned was notified that Claimant died on July 1, 2005. He had a high school degree, (DX 8:12; Tr. 24), and served in the Navy for 33 months. (Tr. 24).

Dependency

On December 24, 1949, Claimant married Iva Cloud, and they remained married and lived together. (DX 4, 8, 10; Tr. 35). Claimant's application noted that his adopted child, William Ronald West, born on December 2, 1953, was over the age of 18, but disabled. (DX 4, 11-13). At the July 12, 2002 deposition, Claimant stated that he did not have any dependant children, explaining that William was hurt on the job and suffered from degenerative spinal disease. (DX 8:5). At the hearing, however, Claimant testified that he claimed William as a dependent even though William was receiving Social Security based on his own previous income. (Tr. 37-38). Claimant also stated the William had been married, and had a child of his own. (Tr. 42). Finally, Claimant testified that William died in August 2003. (Tr. 37, 42).

A "disability" is defined as "the inability to engage in substantial gainful activity by reason of any medically demonstrable physical or mental impairment;" therefore, medical evidence must be produced to establish disability, and the claimant's statements, standing alone, are insufficient to meet the burden of proof. *Tackett v. Director, OWCP*, 10 B.L.R. 1-117 (1987). While Claimant has submitted a Social Security Administration printout showing that it began paying disability benefits to William in August 1995, (DX 13), he has not presented any kind of disability determination either from Social Security or any other source. Therefore, I find that William Ronald West is not a dependent for the purposes of augmentation of benefits. Thus, Iva, Claimant's wife, is Claimant's only dependent for purposes of augmentation..

Procedural History

Claimant filed his first claim for benefits on December 9, 1980. (DX 1). In a decision and order dated May 4, 1989, Administrative Law Judge McCarthy denied benefits, finding that Claimant had not established any of the elements of entitlement.

Claimant filed his second claim for benefits under the Act on January 4, 1995. (DX 2). The District Director, Office of Workers' Compensation, issued a letter dated July 25, 1995. The Director stated that upon review of the evidence in the claim, Claimant was not able to prove any

elements of entitlement. As Claimant failed to submit additional evidence or request a hearing, this claim was deemed abandoned, and thus, administratively closed by letter dated October 17, 1995.

Claimant filed the instant application for benefits on June 22, 2001. (DX 4). On May 15, 2003, the Director issued a proposed decision and order awarding benefits. (DX 38). Employer appealed on May 23, 2003. (DX 39). This matter was transferred to the Offices of Administrative Law Judges on August 19, 2003 for a formal hearing. (DX 45).

Timeliness

Under § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. Section 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

In an unpublished opinion arising in the Sixth Circuit, *Furgerson v. Jericol Mining, Inc.*, BRB Nos. 03-0798 BLA and 03-0798 BLA-A (Sept. 20, 2004) (unpub.), the Benefits Review Board held that *Kirk*, 264 F.3d 602 is controlling and directed the administrative law judge in that case to "determine if [the physician] rendered a well-reasoned diagnosis of total disability due to pneumoconiosis such that his report constitutes a 'medical determination of total disability due to pneumoconiosis which has been communicated to the miner'" under § 725.308 of the regulations.

The Sixth Circuit held in *Kirk*, 264 F.3d 602 that:

> The three-year limitations clock begins to tick the first time that a miner is told by a physician that he is totally disabled by pneumoconiosis. This clock is not stopped by the resolution of a miner's claim or claims, and, pursuant to *Sharondale*, the clock may only be turned back if the miner returns to the mines after a denial of benefits. There is thus a distinction between premature claims that are unsupported by a medical determination, like Kirk's 1979, 1985, and 1988 claims, and those claims that come with or acquire such support. Medically supported claims, even if ultimately deemed "premature" because the weight of the evidence does not support the elements of the miner's claim, are effective to begin the statutory period. [Footnote omitted.] Three years after such a determination, a miner who has not subsequently worked in the mines will be unable to file any further claims against his employer, although, of course, he may continue to pursue pending claims.

At the July 12, 2002 deposition, Claimant stated that his family doctor told him that he should quit working, but that no doctor has ever told him that he was totally disabled from doing any kind of work. (DX 8:22-23). At the hearing, Claimant explained that Dr. Toothman had told him that he needed to get out of coal mining and away from the coal dust. (Tr. 31). An

opinion of the inadvisability of returning to coal mine employment because of pneumoconiosis is not the equivalent of a finding of total disability. *Zimmerman v. Director, OWCP*, 871 F.2d 564, 567 (6th Cir. 1989); *Taylor v. Evans & Gambrel Co.,* 12 B.L.R. 1-83 (1988); *Justice v. Island Creek Coal Co.*, 11 B.L.R. 1-91 (1988); *Bentley v. Director, OWCP*, 7 B.L.R. 1-612 (1984); *Brusetto v. Kaiser Steel Corp.,* 7 B.L.R. 1-422 (1984). Therefore, I find that Dr. Toothman's recommendation to quit coal mining does not constitute a communication to the miner that he was totally disabled due to pneumoconiosis. As a result, I find that Mr. West's claim is timely pursuant to the presumption found at § 725.308(c).

Length of Coal Mine Employment

Claimant was a coal miner within the meaning of § 402 (d) of the Act and § 725.202 of the regulations. On his application for benefits, Claimant stated that he engaged in coal mine employment for 41 years (DX 4). Claimant's last coal mine employment was working as a manager for the safety division. (DX 7, 8:7-8; Tr. 28). Claimant describes the physical requirements of the work to include sitting for 2-3 hours per day, standing for four to five hours per day, crawling up to one hour per day, and carrying 10-15 pounds 1000 feet while standing or walking. (DX 7).

Claimant last worked in and around coal mines until his retirement in 1987 due to inability to continue his mining duties. (DX 4). He noted, however, that at the time he filed his application for benefits, that he was employed as a safety agent for Cumberland Resources Corp. (DX 4). He explained that while Cumberland Resources was a coal company, his job duties consisted of office work, and did not include any work in or around coal mines or preparation plants. (DX 4, 8:6-7). In addition, his employment history form notes that he has worked at Whitaker Coal Co. and Bodie Mining Co. from 1987 through 1991, in a similar role as that performed at Cumberland Resources Corp. (DX 5, 7, 8:14-15). Claimant's summary report notes that all of his work since 1987 has been in the coal mine industry, but that none of it involved exposure to dust, gas, or fumes. (DX 8:16).

The parties stipulate to at least 20 years of coal mine employment. (Tr. 19-20). A review of the record supports this stipulation. (DX 4-9). Therefore, I find that Claimant engaged in qualifying coal mine employment for at least 20 years.

Claimant's last employment was in the Commonwealth of Virginia (DX 4, 5); therefore, the law of the Fourth Circuit is controlling. [4]

Responsible Operator

Liability under the Act is assessed against the most recent operator which meets the requirements of §§ 725.494 and 725.495. The District Director identified Clinchfield Coal Co. as the putative responsible operator because it was the last operator to employ Claimant for a year. (DX 21). The Director further concluded that Claimant's subsequent work for

[4] Appellate jurisdiction with a federal circuit court of appeals lies in the circuit where the miner last engaged in coal mine employment, regardless of the location of the responsible operator. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200 (1989)(en banc).

Cumberland Energy Corp., Cumberland Resources Corp., and Mountain Management Inc., did not involve duties considered coal mining because they were not an integral part of the process of extracting or preparing coal. Clinchfield Coal Co. does not contest its designation. (Tr. 19). Upon review of the record, I find that Clinchfield Coal Co. is properly designated as the responsible operator in this case.

## MEDICAL EVIDENCE

Section 718.101(b) requires any clinical test or examination to be in substantial compliance with the applicable standard in order to constitute evidence of the fact for which it is proffered. *See* §§ 718.102 - 718.107. The claimant and responsible operator are entitled to submit, in support of their affirmative cases, no more than two chest x-ray interpretations, the results of no more than two pulmonary function tests, the results of no more than two blood gas studies, no more than one report of each biopsy, and no more than two medical reports. §§ 725.414(a)(2)(i) and (3)(i). Any chest x-ray interpretations, pulmonary function studies, blood gas studies, biopsy report, and physician's opinions that appear in a medical report must each be admissible under § 725.414(a)(2)(i) and (3)(i) or § 725.414(a)(4). §§ 725.414(a)(2)(i) and (3)(i). Each party shall also be entitled to submit, in rebuttal of the case presented by the opposing party, no more than one physician's interpretation of each chest x-ray, pulmonary function test, arterial blood gas study, or biopsy submitted, as appropriate, under paragraphs (a)(2)(i), (a)(3)(i), or (a)(3)(iii). §§ 725.414(a)(2)(ii), (a)(3)(ii), and (a)(3)(iii). Notwithstanding the limitations of §§ 725.414(a)(2) or (a)(3), any record of a miner's hospitalization for a respiratory or pulmonary or related disease, or medical treatment for a respiratory or pulmonary or related disease, may be received into evidence. § 725.414(a)(4). The results of the complete pulmonary examination shall not be counted as evidence submitted by the miner under § 725.414. § 725.406(b).

Claimant selected Glen Baker, M.D. to provide his Department of Labor sponsored complete pulmonary examination. (DX 14). Dr. Baker conducted the examination on July 25, 2001. I admit Dr. Baker's report under § 725.406(b). I also admit Dr. Sargent's quality-only interpretation of the chest x-ray under § 725.406(c).

Claimant completed a Black Lung Benefits Act Evidence Summary Form. (CX 8). Claimant submitted x-ray readings of the January 30, 2002 film by Dr. Ahmed and Dr. Alexander, as initial evidence, and a reading of the February 17, 2004 film by Dr. Alexander, as rebuttal evidence. Next, Claimant designated Dr. Narayanan's July 26, 2002 PFT and Dr. Craven's September 21, 2001 PFT as initial evidence. Claimant also designated Dr. Smiddy's medical report dated June 24, 2003, and his support letter dated January 5, 2004. As it was not related to treatment, but generated for use in the instant adjudication, I find that Dr. Smiddy's 2004 letter, while designated as "other" evidence, is actually a second medical report. Finally, Claimant submitted hospitalization records and treatment notes from Drs. Smiddy and Rao, and Nurse Kellie Brooks. Claimant's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725.414 (a)(3). Therefore, I admit the evidence Claimant designated in its summary form.

Employer completed a Black Lung Benefits Act Evidence Summary Form. Employer included Dr. Rosenberg's and Dr. Wiot's February 17, 2004 chest x-ray interpretations as initial

evidence, Dr. Wiot's interpretations of the January 30, 2002 and July 25, 2001 chest x-rays as rebuttal evidence, and Dr. Rosenberg's rehabilitation of the March 28, 2005 film. Employer next designated Dr. Rosenberg's PFT and ABG studies dated February 17, 2004 and August 27, 2002, as initial evidence. Employer further designated Dr. Repsher's August 8, 2004 medical report and his January 4, 2005 addendum, and Dr. Rosenberg's November 12, 2004 report and his January 4, 2005 addendum as initial evidence. In addition, Employer included Dr. Caffrey's February 18, 2005 biopsy report and Dr. Wiot's July 30, 2004 CT scan. Finally, Employer supplemented its evidence with depositions by Drs. Rosenberg, Wiot, and Repsher. Employer's evidence complies with the requisite quality standards of §§ 718.102-107 and the limitations of § 725-414 (a)(3). Therefore, I admit the evidence Employer designated in its summary form.

X-RAYS

| Exhibit | Date of X-ray | Date of Reading | Physician / Credentials | Interpretation |
|---|---|---|---|---|
| DX 16 | 7/25/01 | 07/25/01 | Baker[5] | 1/0 pq |
| DX 16 | 7/25/01 | 08/24/01 | Sargent, BCR[6], B-reader[7] | Quality only |
| DX 18, CX 19 | 7/25/01 | 08/28/02 | Wiot, BCR, B-reader | Negative[8] |
| DX 17 | 1/30/02 | 03/06/02 | Ahmed, BCR, B-reader | 1/0 pp |
| DX 19 | 1/30/02 | 09/14/02 | Alexander, BCR, B-reader | 1/2 pp[9] |
| EX 10, 19 | 1/30/02 | 12/13/04 | Wiot, BCR, B-reader | Negative[10] |
| CX 3 | 7/08/03 | 07/08/03 | Westerfield, BCR, B-reader | 1/0 qt[11] |

[5] At the time of the x-ray reading, Dr. Baker did not hold B-reader x-ray interpretation credentials. But the June 7, 2004 "B-reader" list states that he was a B-reader from February 1, 1993 to January 31, 2001, and again from June 1, 2002 to present. Also, he is listed as an A-reader from February 1, 2001 to May 31, 2002.

[6] A physician who has been certified in radiology or diagnostic roentgenology by the American Board of Radiology, Inc., or the American Osteopathic Association. *See* 20 C.F.R. § 727.206(b)(2)(III). The qualifications of physicians are a matter of public record at the National Institute of Occupational Safety and Health reviewing facility at Morgantown, West Virginia.

[7] A "B" reader is a physician who has demonstrated proficiency in assessing and classifying x-ray evidence of pneumoconiosis by successful completion of an examination conducted by or on behalf of the Department of Health and Human Services. This is a matter of public record at HHS National Institute for Occupational Safety and Health reviewing facility at Morgantown, West Virginia. (42 C.F.R. § 37.5l) Consequently, greater weight is given to a diagnosis by a "B" Reader. *See Blackburn v. Director, OWCP*, 2 B.L.R. 1-153 (1979).

[8] Dr. Wiot was deposed by the Employer on February 7, 2005, when he repeated the findings of his earlier written report. (EX 15).

[9] Dr. Alexander noted that the small rounded opacities were located in the mid and upper lung zones, which was consistent with pneumoconiosis, but there were also small, irregular opacities bilaterally in the lower lung zones consistent with asbestosis, category 1/2 st. Dr. Alexander further explained that while it is unusual to have concomitant CWP and asbestosis, he was confident that the two disease processes were present on Claimant's chest film.

[10] Dr. Wiot was deposed by the Employer on February 7, 2005, when he repeated the findings of his earlier written report. (EX 15).

[11] In *Dempsey v. Sewell Coal Co.*, 23 B.L.R. 1-47 (2004) (en banc), the Board held that treatment records, containing multiple pulmonary function and blood gas studies that exceed the limitations at § 725.414, are properly admitted. This is so regardless of whether the records are offered by a claimant or an employer. It is noted, however, that the Board required that, on remand, the administrative law judge must "analyze each set of records and made a specific finding as to its (sic) admissibility under § 725.414(a)(4)." I find that this reasoning applies

| | | | | |
|---|---|---|---|---|
| EX 1 | 2/17/04 | 02/17/04 | Rosenberg, B-reader | 2/2 st [12] |
| EX 9, 15 | 2/17/04 | 12/13/04 | Wiot, BCR, B-reader | Negative[13] |
| CX 7 | 2/17/04 | 01/15/05 | Alexander, BCR, B-reader | 1/1 pp[14] |

PULMONARY FUNCTION TESTS

| **Exhibit/ Date** | **Co-op./ Undst./ Tracings** | **Age/ Height**[15] | **$FEV_1$** | **FVC** | **MVV** | **$FEV_1$/ FVC** | **Qualifying Results** |
|---|---|---|---|---|---|---|---|
| DX 16 7/25/01 | Fair/ Good/ Yes | 76 65.75" | **1.18** | 2.07 | **52** | 57 | **Yes**[16] |
| DX 17 9/21/01 | Good/ Good/ Yes | 76 68" | **1.11** | **1.97** | **59.5** | 56.34 | **Yes** |
| DX 17[17] 7/26/02 | ---- | ---- | ---- | ---- | ---- | ---- | |
| EX 1 | Good/ | 77 | **1.28** | 2.29 | **57** | 56 | **Yes** |

equally to x-ray interpretations included in the treatment records. Therefore, I find that this x-ray is admissible as a treatment record under §725.414(a)(4). *See* note 22, *infta*.

[12] Dr. Rosenberg emphasized that this x-ray did not demonstrate evidence of CWP, but instead, what he referred to as linear changes in the lower fields that was unrelated to coal dust exposure. (EX 1-4). Dr. Repsher, a B-reader, noted, however, that Dr. Rosenberg read the February 17, 2004 x-ray as positive for simple pneumoconiosis (not CWP), and emphasized that Dr. Rosenberg was only a B-reader.

[13] Dr. Wiot was deposed by the Employer on February 7, 2005, when he repeated the findings of his earlier written report. (EX 15).

[14] While Dr. Alexander marked the boxes noting that Claimant had 2/1 tt pneumoconiosis, his comments read as follows: asbestos disease of the pleura and asbestos; small round opacities in the upper zones consistent with CWP 1/1 pp; and a 2 cm mass in the right upper zone that is suspicious for lung cancer. Based on the narrative comments concerning his September 14, 2002 x-ray interpretation report, it is apparent that Dr. Alexander has separately diagnosed both CWP and asbestosis, and designated separate opacity values for each condition. *See* note 9. Therefore, as evidenced by Dr. Alexander's direct narrative statement, I find that the pneumoconiosis opacity values of this report are 1/1 pp.

Dr. Rosenberg submitted a rehabilitative report on March 28, 2005. (DX 20). He stated that upon reconsideration, despite what Dr. Alexander has opined, the film does not demonstrate any micronodularity. However, it does demonstrate liner changes in the mid and lower lung zones with pleural abnormalities, which are not coal mine dust related. Dr. Rosenberg concluded that his previous interpretation remains unchanged, reiterating that Claimant does not have CWP or any associated impairment. Also, while Dr. Rosenberg is a certified B-reader, he stated that since the film he received was a copy of the original, a formal B-reading was not performed on rehabilitation.

[15] I must resolve the height discrepancy recorded on the pulmonary function tests. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221 (1983). At the hearing, Claimant testified that he was 67 inches tall. (Tr. 24). In addition, 67 inches is roughly the median of the heights reported in the PFT studies. Therefore, I find that the miner's actual height is 67 inches.

[16] This PFT was validated by Dr. Michos, an internist and pulmonologist. (DX 16).

[17] Claimant designated Dr. Narayanan's July 26, 2002 PFT in its summary form. While the cover letter for DX 17 states that the submission includes this report, the actual test is not included.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 8/27/02 | Good/<br>Yes | 68” | **1.35*** | 2.32* | 67* | 58* | No* |
| CX 1<br>6/24/03 | Good/<br>Good/<br>Yes | 78<br>67” | **1.13**<br>**1.29*** | 2.12<br>2.24* | ---- | **53**<br>58* | **Yes**[18]<br>No |
| EX 1<br>2/17/04 | Good/<br>Good/<br>Yes | 78<br>66” | **.78** | **1.72** | **38** | **45** | **Yes** |

* post-bronchodilator values

ARTERIAL BLOOD GAS STUDIES

| **Exhibit** | **Date** | **$pCO_{2*}$** | **$pO_{2*}$** | **Qualifying** |
|---|---|---|---|---|
| DX 16 | 7/25/01 | 44 | 73 | No |
| EX 1 | 8/27/02 | 39.7 | 73.6 | No |
| EX 1 | 2/17/04 | 39.2 | 75 | No |

All values pre-exercise

Treatment Records

Dr. Joseph Smiddy, an internist who is Board eligible for the pulmonary disease sub-specialty, examined Claimant and submitted a report dated June 24, 2003 (CX 1).[19] Dr. Smiddy considered the following: symptomatology (shortness of breath, exercise limitation, wheezes, orthopnea, and white sputum), employment history (41 years underground), individual history (prior heart bypass, kidney dialysis, bladder tumor, prostate surgery, heart attack, hypertension, lung cancer, and lung disease), smoking history (smoked from age 21 to 60), physical examination (harsh, decreased breath sounds), chest x-ray[20] (micronodular change consistent with significant CWP in five lobes), and a PFT (profound restrictive defect and severe obstructive lung disease). Dr. Smiddy diagnosed CWP, COPD, and bronchitis. As a result, he

[18] This PFT is admissible as a treatment record under §725.414(a)(4). *See* note 19**.**

[19] Dr. Smiddy noted that Claimant was a referral patient from Dr. Kaw. The report, however, also thanks Dr. Kaw for allowing Pulmonary Associates to assist in the care of Claimant, and includes a plan for ongoing treatment. Thus, while Claimant testified that he has been treated by Dr. Smiddy for his breathing condition since early 2004, (Tr. 33), I find that Claimant’s treatment with Dr. Smiddy actually began with this June 2003 examination. (CX 1). As a result, I find that this report can either be considered a medical report or a treatment record, and since it includes a PFT report that was not designated by Claimant, and would exceed the limitations of §725.414 if considered as a medical report, I will consider this report as a treatment record. Therefore, all of Dr. Smiddy’s conclusions and PFT findings are admissible as treatment records under § 725.414(a)(4).

[20] There is no evidence in the record as to Dr. Smiddy’s x-ray reading credentials. Also, there is no record of the film quality for this x-ray. As a result, despite the fact Dr. Smiddy unequivocally determines that the x-ray demonstrates pneumoconiosis, his interpretation is not in compliance with the quality standards of §718.102 and Appendix A to Part 718. Therefore, I accord Dr. Smiddy’s x-ray interpretation contained in this treatment record no weight for the purpose of determining whether Claimant suffers from pneumoconiosis under § 718.202(a)(1).

opined that Claimant was 100% totally and permanently disabled by CWP, although multiple concomitant diseases were present.

Dr. Smiddy submitted a follow-up report dated July 8, 2003. (CX 2) Noting that Claimant has a severe impairment as evidenced by the prior PFT, and that he is totally disabled due to CWP, Dr. Smiddy stated that Claimant is slightly improved after adding Combivent and Advair. He also noted that Claimant's physical examination results are unchanged, and that Claimant was scheduled for a B-reading on July 8, 2003.

Dr. Ramesh Rao submitted a consultation note on September 14, 2004, for the purpose of evaluating Claimant's recently diagnosed nonsmall cell carcinoma of the lung. (CX 4). Dr. Rao provided a detailed summary of the steps taken to diagnose lung cancer, including a discussion of a July 27, 2004 CT scan (enlarged azygos node which measured 2/5 cm; a large lobulated mass located medically within the right upper lobe; and extensive pleural thickening noted at both lung bases associated with subpleural bands), and an August 19, 2004 fine needle aspiration biopsy and core needle biopsy of the right upper lobe mass (poorly differentiated nonsmall cell carcinoma). Dr. Rao also considered individual history (heart bypass surgery, hypertension, kidney dialysis, bladder tumor and prostate surgery), family history (cancer, lung disease, and heart disease), employment history (more than 40 years as an underground coal miner), smoking history (smoked cigarettes between the ages of 21 and 60), symptomatology (shortness of breath on exertion), and a physical examination (both lungs were clear to auscultation with very much diminished breath sounds bilaterally). Dr. Rao diagnosed clinical Stage III B nonsmall cell carcinoma of the lung, primarily in the right upper lobe of the lung with mediastinal lymph node involvement as per PRT scan, and prescribed a medical oncology evaluation and treatment recommendation.

Kellie Brooks, a RN, FNP and LNP, provided treatment records dated December 17, 2001. (CX 5). Based on a physical examination (no relevant findings), employment history (41 years coal mine employment, last working as a safety director), symptomatology (shortness of breath on exertion, sputum production, and orthopnea), smoking history (quit in 1985), family history (throat cancer, hypertension, heart disease, and arthritis), individual history (COPD, hypertension, 4xCABG in 2000, renal artery blockage with stint placement and dialysis, and bladder cancer), Nurse Brooks concluded that Claimant suffered from COPD.

Narrative Reports

Dr. Glen Baker examined Claimant on July 25, 2001. (DX 16). Dr. Baker considered the following: symptomatology (sputum, wheezing, dyspnea, cough, and chest pain), employment history (41 years underground, last working as a safety director), individual history (pleurisy, attacks of wheezing, chronic bronchitis, arthritis, allergies, bladder cancer, high blood pressure, and a four vessel CABG in 2000), family history (high blood pressure, heart disease, and cancer), smoking history (1943 to 1985 at a rate of one pack per day), physical examination (no relevant findings), chest x-ray (1/0), PFT (moderate obstructive defect), ABG (mild resting arterial hypoxemia), and an EKG (normal sinus rhythm, left axis deviation, and diffuse ST-T changes). Dr. Baker diagnosed CWP based on the chest x-ray and coal dust exposure; COPD with moderate obstructive defect based on the PFT; and mild resting hypoxemia based on the

ABG study. Also, he attributed Claimant's CWP to coal dust exposure, and the COPD and hypoxemia to coal dust exposure and cigarette smoking, and found that these conditions, along with chronic bronchitis, resulted in a moderate impairment. Dr. Baker concluded that based on the FEV1 at 48% of predicted, that Claimant does not have the respiratory capacity to perform the work of a coal miner or to perform comparable work in a dust-free environment.

Dr. Smiddy submitted a letter dated January 5, 2004. (CX 3). Dr. Smiddy considered the following: symptomatology (persistent cough, shortness of breath, and exercise limitations), employment history (41 year as an underground coal miner, most recently as a foreman and inspector), individual history (diagnosed on multiple occasions to have CWP), smoking history (on record in office), physical examination (on record in the office), a PFT (June 24, 2003 test[21]), and chest x-ray (July 8, 2003 B-reading finding 1/0 pneumoconiosis[22]), Dr. Smiddy concluded that Claimant was 100% totally and permanently disabled by CWP, noting that while Claimant does have multiple concomitant underlying diagnoses, his pneumoconiosis is of a sufficient degree to be disabling in and of itself.

Dr. David Rosenberg, an internist, pulmonologist, and B-reader, examined the Claimant on August 27, 2002 and submitted a report dated November 12, 2004 (EX 1, 16). Dr. Rosenberg considered the following medical reports: Central Baptist Hospital Records[23]; Dr. Baker's July 25, 2001 complete pulmonary evaluation; Dr. Alexander's and Dr. Ahmed's interpretations of the January 30, 2002 x-ray; Dr. Wiot's and Dr. Sargent's interpretations of the July 25, 2001 chest x-ray, Dr. Craven's September 21, 2001 PFT, and a majority of the medical evidence submitted in conjunction with the prior claims. In addition, he considered the following findings: symptomatology (decreased stamina, shortness of breath; cough, sputum production, swelling, and palpitations), employment history (41 years underground, with the last 10 spent as a safety director requiring him to walk up to three miles per day and carry 15 pounds of equipment), individual history (coronary artery bypass surgery in 2000, renal failure, stint placement, and bladder cancer with surgery in 1985), family history (lung cancer and heart disease), smoking history (about 1 pack per day for 40 years, until 1985), August 27, 2002 physical examination (equal expansion of his chest without rales, rhonchi or wheezes), February 17, 2004 physical examination (equal expansion of the chest without rales, rhonchi, or wheezes), August 27, 2002 chest x-ray (pleural changes bilaterally, with some linear interstitial changes in the lower lung fields)[24], February 17, 2004 chest x-ray, (liner changes in the mid and lower fields

[21] This PFT was part of the June 24, 2003 treatment report, discussed above, and is admitted as a treatment PFT under § 725.414(a)(4). *See* note 19.

[22] In Dr. Smiddy's June 24, 2003 treatment report, he stated that a B-reader chest x-ray "may be of value." (CX 1). Also, in his July 8, 2003 treatment report, Dr. Smiddy stated, "We discussed the merits of a B-Reader chest x-ray, and the patient would like to proceed, and this is scheduled." (CX 2). As the July 8, 2003 x-ray interpretation by Dr. Westerfield, a B-reader, took place on the same day as Dr. Smiddy's treatment report ordering such a study, I find that this chest film is actually a treatment record. Therefore, I find that the evidence considered by Dr. Smiddy's report is all admissible under the limitations of §725.414. *See* note 11, and citation to *Dempsy v. Sewell Coal Co.* included therein, *supra*.

[23] This treatment evidence is included in the record as DX 15, but was not designated by either party. As all treatment records are admissible under §725.414(a)(4), I find that it may be considered as part of a medical evidence review without exceeding the limitations of §725.414. *Ibid.* Therefore, Dr. Rosenberg's conclusions based on this information are also admissible.

[24] This x-ray interpretation was not designated in either of the evidence summary forms, and inclusion violates the limitations of §§725.414. §§725.414 (a)(2)(i) and (3)(i). As a result, any opinions based on this x-ray

with a category 2 thickness; density seen in the right paratracheal region, circular density in the right lower), August 27, 2002 PFT (no significant bronchodilator response), February 17, 2004 PFT (significant obstruction), August 27, 2002 ABG, February 17, 2004 ABG (normal), August 12, 2004 EKG (T wave changes, left axis deviation), and a February 17, 2004 EKG (intraventicular conduction delay with some nonspecific T-wave changes and left axis deviation).

Dr. Rosenberg stated that Claimant's does not have micronodularity associated with past coal dust exposure, as evidenced by the overwhelming majority of x-ray readings over the years that have found him negative for the presence of micronocularity; a restriction that has occurred in a setting of linear basilar changes and pleural abnormalities, which do not relate to coal dust exposure; a normal diffusing capacity corrected for lung volumes; and the absence of rales on auscultation.

Turning to lung function, Dr. Rosenberg opined that Claimant has a moderate restriction with severe obstruction, and therefore, "clearly could not perform his previous coal mining job, with his impairments having worsened since he left the coal mine industry." Dr. Rosenberg explained that Claimant's restriction "probably relates to his underlying linear lung disease and pleural abnormalities, [but] these abnormalities do not relate and have not been caused or hastened by past coal dust exposure." Next, he opined that the significant obstructive component, demonstrated by reduced FEV1 values, was not related to past coal dust exposure because the medical literature explains that obstruction does not worsen, as Claimant's has, after a miner leaves the coal mines. He further explained that while pneumoconiosis is progressive, this progression relates to micrododular changes related to CWP and the development of progressive massive fibrosis, but that the literature shows that once a miner is no longer exposed to coal dust, progressive airflow obstruction would not occur. Based on this explanation, Dr. Rosenberg concluded that Claimant's totally disabling severe obstruction is the result of cigarette smoking coupled with the restriction resulting from non-coal mine related linear and pleural abnormalities, and has not been caused or hastened by past inhalation of coal mine dust.

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interpretation are not admissible in the instant adjudication. Dr. Rosenberg however, reached his conclusion concerning the x-ray evidence based not only on the large number of x-ray interpretations from the prior claims, and many of those designated in the instant claim, including his own February 17, 2004 interpretation. Furthermore, the emphasis of his opinion is clearly placed with the February 17, 2004 x-ray interpretation, both in his November 2004 report and the December 3, 2004 deposition. Specifically, Dr. Rosenberg attached an actual B-reading report of the February 17th film to his 2004 report while he makes only a passing narrative reference to his August 27, 2002 chest x-ray interpretation. Finally, I am convinced that Dr. Rosenberg placed relatively less weight on the inadmissible x-ray, considering the fact that his narrative description of this film is nearly identical to his subsequent, admissible reading.

I find that while Dr. Rosenberg's November 2004 narrative report included this inadmissible 2002 x-ray interpretation, it is questionable whether he considered this interpretation, or how much weight he accorded this film in reaching his ultimate conclusion. Furthermore, even if Dr. Rosenberg had specifically relied upon his August 27, 2002 x-ray interpretation, I find this consideration to be harmless since he also conducted a subsequent B-reading that reiterated his previous findings. *Stanford v. Director, OWCP*, 7 B.L.R. 1-541 (1984) (holding that it is generally proper to accord greater weight to the most recent x-ray study of record). Therefore, I find good cause to admit Dr. Rosenberg's November 2004 narrative report despite its mention of the August 27, 2002 chest x-ray reading.

Dr. Rosenberg was deposed by the Employer on December 3, 2004, when he repeated the findings of his earlier written report. (EX 2). Dr. Rosenburg explained that while his February 17, 2004 x-ray interpretation noted pleural abnormalities consistent with pneumoconiosis, 2/2 st, the type of liner changes identified "can be formed by other kinds of dust conditions, pneumoconiosis such as asbestosis conditions, … non work-related conditions, … and a variety of medications can do it…." (EX 2: 22-24). He further explained that when it is not possible to identify a specific etiology, these types of linear changes are referred to as idiopathic pulmonary fibrosis or nonspecific interstitial puenmonitis. (EX 2: 24). As a result, Dr. Rosenburg opined that the x-ray results were not characteristic of the kinds of pathogenic problems which occur with coal dust exposure because coal dust typically involves nodular changes, not linear changes. (EX 2: 24-25). Concerning the restrictive component of his PFT report, Dr. Rosenberg added that Claimant did not have the micronodular changes that are typical with coal dust exposure and CWP, but were related to a linear type disease in the wrong area of the lung – lower instead of upper – than you would see with CWP. (EX 26). As a result, Dr. Rosenberg concluded that Claimant's restriction was not from coal dust exposure. Finally, concerning his medical evidence review, Dr. Rosenberg noted that Claimant's pulmonary function has deteriorated markedly over the last couple of years, but this is not related to coal dust exposure. (EX 2: 30).

Dr. Rosenberg submitted an addendum to his report on January 4, 2005. (EX 3). This report considered the following additional medical records: Dr. Smiddy's June 24, 2003 and July 8, 2003 reports, and support letter dated January 5, 2004; Dr. Rao's consultation note; and Nurse Brooks December 17, 2001 report. Based on this additional information, Dr. Rosenberg concluded that Claimant had cancer, and while Dr. Westerfield noted micronodular changes, Dr. Rosenberg, noted that the majority of other B-readers in the file had not observed such changes. In addition, he reiterated his opinion that Claimant's restriction "undoubtedly relates to his pleural abnormalities and linear lung disease, neither of which is coal dust related." Thus, he opined that Claimant does not have the interstitial form of CWP. As a result, Dr. Rosenberg stated that these additional reports have not changed his previous conclusions.

Dr. Rosenberg was deposed by the Employer on March 3, 2005, when he repeated the findings of his earlier written report. (EX 4).

Dr. Lawrence Repsher, an internist, pulmonologist, and B-reader, performed a medical evidence review, and submitted a report dated December 8, 2004 (EX 5, 17). Dr. Repsher considered the following: employment history (34-41 years as an underground coal miner, most recently as a federal mine inspector and a safety officer, which was primarily a desk job), individual history (chronic bronchitis, pulmonary emphysema secondary to cigarette smoking, carcinoma of the bladder, hypertension, a coronary artery bypass in 2000, and angioplasty with stint placement in the coronary artery in 2000), family history (emphysema, lung and throat cancer, hypertension, and heart disease), smoking history (one pack per day for 40 to 42 years, quitting in 1985), February 17, 2004 chest x-rays (0/0)[25], the newly submitted medical reports

[25] This x-ray interpretation was not designated in either of the evidence summary forms, and inclusion violates the limitations of §§725.414. §§725.414 (a)(2)(i) and (3)(i). As a result, any opinions based on this x-ray interpretation are not admissible in the instant adjudication. Also, I do not find Dr. Repsher's reliance on his own interpretation of the February 17, 2004 x-ray to be harmless. Dr. Repsher's December 2004 report, January 2005 report, and March 2005 deposition all state that Claimant has no chest x-ray evidence of CWP as interpreted by

(Dr. Baker's July 25, 2001 complete pulmonary evaluation[26], Dr. Rosenberg's February 17, 2004 report[27], and the September 21, 2001 PFT), and a great deal of the evidence submitted in Mr. West's prior claims. Dr. Repsher found no evidence of CWP or any other pulmonary or respiratory disease or condition, either caused by or aggravated by his employment as a coal miner with exposure to coal dust, but instead, diagnosed COPD and pulmonary emphysema secondary to cigarette smoking. He explained that none of the x-ray[28] , history, PFT, or ABG evidence supports a finding of CWP. He added that Claimant's severe obstructive ventilatory impairment and COPD are due to the long history of cigarette smoking, and his restrictive disease is due to postoperative respiratory complications for the July 2000 CABG surgery, but that none of these conditions are due to coal dust exposure. In addition, he stated that Claimant's x-ray abnormalities are also the result of postoperative complications from the July 2000 CABG.

Dr. Repsher submitted an updated copy of his previous report on January 4, 2005 (EX 6). This report considered the following additional medical records: Dr. Smiddy's June 24, 2003 and July 8, 2003 reports, and support letter dated January 5, 2004; Dr. Westerfield's reading of the July 8, 2003 x-ray; and Nurse Brooks December 17, 2001 report. Dr. Repsher discounted Dr.

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multiple board certified radiologists and B-readers. This conclusion is problematic considering the fact that Dr. Rosenberg's B-reading of the February 17, 2004 film, which Dr. Repsher considered to be positive for simple pneumoconiosis but not CWP; and the next most recent interpretation considered by Dr. Repsher, Dr. Westerfied's July 8, 2003 BCR and B-reading, was positive for pneumoconiosis. I also note that Dr. Repsher never mentioned whether he saw Dr. Wiot's negative reading of the February 17, 2004 film. As a result, the record before Dr. Repsher included a large number x-ray interpretations over the course of several years, culminating with two positive, credentialed readings, but he still concluded that there was no chest x-ray evidence of pneumoconiosis. Assuming that Dr. Repsher is aware that pneumoconiosis is a progressive disease, and thus, the most recent x-rays are the most probative, the undersigned is left only to infer that Dr. Repsher placed great weight on his own inadmissible B-reading of the February 17, 2004 chest film. As a result, I find that Dr. Repsher's inclusion of his own reading had a significant impact on his ultimate conclusions. Therefore, his opinions as to the absence of pneumoconiosis by x-ray evidence are inadmissible as he considered evidence that exceeds the limitations of §725.414.

As detailed above, Employer has designated Dr. Wiot's interpretation of the February 17, 2004 chest x-ray. As Dr. Wiot is a radiologist and B-reader, disallowing Dr. Repsher's report probably does not make a great deal of difference in the ultimate outcome of this claim. The regulations as interpreted by the Benefits Review Board are quite specific on this point, and the limitations are not optional. *See, e.g., Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-__, BRB No. 04-0126 BLA (Oct. 27, 2004) ( "the parties must present their evidence as delineated in Section 725.414"); *Gilbert v. Consolidation Coal Co.*, BRB Nos. 04-0672 BLA and 04-0672 BLA-A (May 31, 2005) (unpub.) (holding that the evidentiary limitations set forth at §725.414 are mandatory and, absent a finding of "good cause," it was proper for the ALJ to exclude the deposition testimony offered by Employer of Claimant's treating physician). And while there may be a valid argument for a "good cause" admission of this excessive x-ray, the undersigned believes that simply allowing an x-ray into evidence for no other reason than to salvage a wayward report that placed a great deal of reliance on that x-ray, is not sufficient to justify "good cause." Furthermore, Dr. Repsher's inclusion of a non-designated x-ray is not the same as the issue presented in Dr. Rosenberg's report, *see* note 24, in that I found good cause to admit Dr. Rosenberg's report despite his mention of an inadmissible x-ray because I found that he did not place much emphasis on the violating interpretation, and would have reached the same conclusion based on his own subsequent, admissible x-ray reading. Therefore, I do not find good cause to admit Dr. Repsher's February 17, 2004 x-ray interpretation, and his resulting conclusions concerning the existence of pneumoconiosis by x-ray evidence.

[26] Dr. Repsher noted that the July 25, 2001 PFT was invalid.

[27] Dr. Repsher noted that the February 17, 2004 PFT was invalid.

[28] Dr. Repsher qualified this conclusion by stating that he relied on the opinions by a majority of the B-readers that interpreted Claimant's prior chest films.

Rosenberg's and Dr. Smiddy's opinions based on the premise that Claimant was still doing the same job in 2004 that he had been doing during the last 10 years of coal mine employment.[29] While this report was basically a reiteration of his previous report, there were a couple of key additions. First, Dr. Repsher noted the existence of Stage III B non-small cell bronchogenic cancer. Second, in support of his opinion as to the cause of Claimant's COPD, Dr. Repsher explained that for any individual coal miner, the "overwhelming probability" is that any detectable COPD would be the result of cigarette smoking or asthma, and not coal dust exposure. Thus, he opined that it was "very unlikely" that coal dust would be the cause of Claimant's COPD.

Dr. Repsher was deposed by the Employer on March 28, 2005, when he repeated the findings of his earlier written report. (EX 7). Dr. Repsher stated that it was difficult to determine whether Claimant was totally disabled from a respiratory or pulmonary standpoint due to the fact that his most recent pulmonary function tests were not interpretable due to poor effort and cooperation.[30] (EX 7: 33-34). He added that if Claimant did have any significant impairment or disability, it would be due to cigarette smoking and not coal dust inhalation. However, he also stated that he does not believe Claimant has a totally disabling respiratory impairment. (EX 7: 41). Finally, Dr. Repsher reiterated that most of Claimant's physical ailments, including panobular emphysema, coronary artery disease, bladder cancer, and Stage III B non-small cell bronchogenic cancer cannot be the result of coal dust exposure, and in this case are related to cigarette smoking. (EX 7: 36-40).

Biopsy Report

Dr. Raphael Caffrey, a pathologist, submitted a pathology consultation report on February 18, 2005. (EX 8, 19). Dr. Caffrey reviewed the following: Cytology report from Highlands Pathology Consultants, P.C. dated August 19, 2004, which did not include the cytology slides; the surgical pathology report from Highlands Pathology Consultants, P.C., dated August 19, 2004; three surgical pathology slides; and a medical history and examination for CWP on Rufus W. Tolliver by Dr. Graziano, dated July 17, 2000.[31] On microscopic

[29] Claimant submitted a letter dated June 16, 2003, which explained the exertional requirements of his work with Cumberland Resources Corp. since leaving the mines in 1987. (CX 6). Claimant explained that he consulted an average of two days per week, and 95% of his work took place in an office environment. He further explained that his supervisors were aware of his physical limitations and liabilities, and respected them. Claimant's description of this post-1987 work is consistent with his hearing testimony, (Tr. 27-28), and his employment description, (DX 7), and includes none of the exertional requirements necessary to perform his pre-1987 work. (DX 7). Therefore, I find the work that Claimant performed after 1987 requires substantially less physical exertion that his job before 1987.

[30] I note that Dr. Repsher's previous report stated that the July 25, 2001 and February 17, 2004 PFTs were invalid. Also, as noted above, the actual test reports reflected fair or good cooperation and effort. Dr. Repsher does not provide any type of explanation for contradicting the findings of the conducting physicians.

[31] The record in this claim does not include a report by Dr. Graziano, nor any other report dated July 17, 2001. Apparently, Dr. Caffrey prepared a previous pathology report for Rufus W. Tolliver and simply failed to delete this reference. Regardless, as the dates of the evidence reviewed by Dr. Caffrey match the dates supplied by Dr. Rao, and Dr. Caffrey mentions Mr. West by name throughout his opinion, I find that the reference to Dr. Graziano's report is harmless. Furthermore, as Dr. Caffrey's conclusions concerning the biopsy evidence seem to be based solely on his microscopic examination, his report will not be discounted for consideration of evidence outside the record.

examination, Dr. Caffrey identified fairly large, irregular, carcinoma cells that showed very hyoerchromatic nuclei with a small amount of cytoplasm. He also found a very slight amount of anthracotic pigment but no CWP lesions. Taking into consideration 24 years of coal mine employment, Dr. Caffrey diagnoses bronchogenic carcinoma. He also stated that the biopsy of the right upper lobe of the lung definitely showed no findings of CWP, and the anthracotic pigment is seen only in a few areas and is definitely not consistent with CWP.

CT Scan Report

Dr. Wiot, a radiologist and B-reader, submitted a letter on February 1, 2005 stating that he had reviewed Claimant's July 30, 2004 chest CT scans. Dr. Wiot stated that since only the mediastinal windows were submitted, it was not possible to interpret the presence or absence of CWP. (EX 11, 18).

Dr. Wiot was deposed by the Employer on February 7, 2005. (EX 15). While Employer stated that this deposition supported the February 1, 2005 CT scan report, the undersigned found that the deposition included no mention to this or any other CT scans.

Smoking History

At the hearing and at the deposition, Claimant testified that he smoked a pack of cigarettes per day for 40 years, but quit in 1985. (DX 8:20; Tr. 42). Dr. Baker reported a smoking history from 1943 to 1985 at a rate of one pack per day, or 42 pack-years. (DX 16). Dr. Smiddy reported a smoking history from age 21 to 60, or 39 years. (CX 1). Dr. Rao reported that Claimant smoked cigarettes between the ages of 21 and 60, or 39 years. (CX 4). Nurse Brooks reported that Claimant quit smoking in 1985. (CX 5). Dr. Repsher reported that Claimant smoked one pack per day for 40 to 42 years, quitting in 1985, or 40 to 42 pack-years. (EX 5). Dr. Rosenberg reported a smoking history of about 1 pack per day for 40 years, quitting in 1985, or 40 pack-years. (EX 1).

All of the newly submitted medial reports record between a 39 and 42 pack-year smoking history, ending in 1985. As this generally supports Claimant's hearing and deposition testimony, I find that Claimant has a 40 pack-year smoking history, but quit smoking in 1985.

## DISCUSSION AND APPLICABLE LAW

Mr. West's claim was made after March 31, 1980, the effective date of Part 718, and must therefore be adjudicated under those regulations. To establish entitlement to benefits under Part 718, Claimant must establish, by a preponderance of the evidence, that he:

1. Is a miner as defined in this section; and

2. Has met the requirements for entitlement to benefits by establishing that he:

   (i) Has pneumoconiosis (see § 718.202), and

(ii) The pneumoconiosis arose out of coal mine employment (see § 718.203), and

(iii) Is totally disabled (see § 718.204(c)), and

(iv) The pneumoconiosis contributes to the total disability (see § 718.204(c)); and

3. Has filed a claim for benefits in accordance with the provisions of this part.

Section 725.202(d)(1-3); *see also* §§ 718.202, 718.203, and 718.204(c).

Subsequent Claim

The provisions of § 725.309 apply to new claims that are filed more than one year after a prior denial. Section 725.309 is intended to provide claimants relief from the ordinary principles of *res judicata*, based on the premise that pneumoconiosis is a progressive and irreversible disease. *See Lukman v. Director, OWCP*, 896 F.2d 1248 (10th Cir. 1990); *Orange v. Island Creek Coal Compamy*, 786 F.2d 724, 727 (6th Cir. 1986); § 718.201(c) (Dec. 20, 2000). The amended version of § 725.309 dispensed with the material change in conditions language and implemented a new threshold standard for the claimant to meet before the record may be reviewed *de novo*. Section 725.309(d) provides that:

> If a claimant files a claim under this part more than one year after the effective date of a final order denying a claim previously filed by the claimant under this part, the later claim shall be considered a subsequent claim for benefits. A subsequent claim shall be processed and adjudicated in accordance with the provisions of subparts E and F of this part, except that the claim shall be denied unless the claimant demonstrates that one of the applicable conditions of entitlement (see § 725.202(d) miner. . .) has changed since the date upon which the order denying the prior claim became final. The applicability of this paragraph may be waived by the operator or fund, as appropriate. The following additional rules shall apply to the adjudication of a subsequent claim:
>
> (1) Any evidence submitted in conjunction with any prior claim shall be made a part of the record in the subsequent claim, provided that it was not excluded in the adjudication of the prior claim.
>
> (2) For purposes of this section, the applicable conditions of entitlement shall be limited to those conditions upon which the prior denial was based. For example, if the claim was denied solely on the basis that the individual was not a miner, the subsequent claim must be denied unless the individual worked as a miner following the prior denial. Similarly, if the claim was denied because the miner did not meet one or more of the eligibility criteria contained in part 718 of the subchapter, the subsequent claim must be denied unless the miner meets at least one of the criteria that he or she did not meet previously.

> (3) If the applicable condition(s) of entitlement relate to the miner's physical condition, the subsequent claim may be approved only if new evidence establishes at least one applicable condition of entitlement. . . .
>
> (4) If the claimant demonstrates a change in one of the applicable conditions of entitlement, no findings made in connection with the prior claim, except those based on a party's failure to contest an issue, shall be binding on any party in the adjudication of the subsequent claim. However, any stipulation made by any party in connection with the prior claim shall be binding on that party in the adjudication of the subsequent claim.

Section 725.309(d) (April 1, 2002).

In *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F.3d 467 (6th Cir. 2003), a multiple claim arising under the pre-amendment regulations at 20 C.F.R. § 725.309 (2000), the court reiterated that its previous decision in *Sharondale Corp. v. Ross*, 42 F.3d 993 (6th Cir. 1994) requires that the ALJ resolve two specific issues prior to finding a "material change" in a miner's condition: (1) whether the miner has presented evidence generated since the prior denial establishing an element of entitlement previously adjudicated against him; and (2) whether the newly submitted evidence differs "qualitatively" from evidence previously submitted. Specifically, the *Flynn* court held that "miners whose claims are governed by this Circuit's precedents must do more than satisfy the strict terms of the one-element test, but must also demonstrate that this change rests upon a qualitatively different evidentiary record." *See also, Tennessee Consolidated Coal Co. v. Kirk*, 264 F.3d 602, 608-610 (6th Cir. 2001). Once a "material change" is found, then the ALJ must review the entire record *de novo* to determine ultimate entitlement to benefits.

Claimant's prior claim was denied after the Director determined that Claimant failed to establish any of the elements of entitlement. (DX 2). Consequently, the Claimant must establish, by a preponderance of the newly submitted evidence, the presence of pneumoconiosis, that pneumoconiosis was caused by coal mine employment, or the existence of a totally disabling respiratory impairment caused by pneumoconiosis. If Claimant is able to prove any of these elements, then he will avoid having his subsequent claim denied on the basis of the prior denial.

Total Disability

Claimant may establish a material change in conditions by demonstrating that he is totally disabled from performing his usual coal mine work or comparable work due to pneumoconiosis under one of the five standards of § 718.204(b) or the irrebuttable presumption referred to in § 718.204(b). The Board has held that under § 718.204(b), all relevant probative evidence, both like and unlike must be weighed together, regardless of the category or type, in the determination of whether the Claimant is totally disabled. *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195 (1986); *Rafferty v. Jones & Laughlin Steel Corp.*, 9 B.L.R. 1-231 (1987). Claimant must establish this element of entitlement by a preponderance of the evidence. *Gee v. W.G. Moore & Sons*, 9 B.L.R. 1-4 (1986).

There is no evidence in the record to show that Claimant suffered from complicated pneumoconiosis. Therefore, the irrebuttable presumption of § 718.304 does not apply.

Total disability can be shown under § 718.204(b)(2)(i) if the results of PFT studies are equal to or below the values listed in the regulatory tables found at Appendix B to Part 718. The newly submitted PFT evidence includes five qualifying, pre-bronchodilator, sets of values and two non-qualifying, post-bronchodilator, sets of values. In addition, a review of the values from 2001 through 2004 shows a general decline in pulmonary function, from Claimant demonstrating FEV1 and MVV qualifying values in July 2001, to qualifying in every category by February 2004. In addition, while there may be a bronchoreversability argument for not finding Claimant totally disabled, none of the experts of record have presented such an opinion. Therefore, based on the downward trends in pulmonary function, and the fact that most of the newly submitted PFTs are qualifying under the regulatory tables found at Appendix B to Part 718, I find that Claimant has established total pulmonary disability under subsection (b)(2)(i).

Total disability can be demonstrated under § 718.204(b)(2)(ii) if the results of ABG studies meet the requirements listed in the tables found at Appendix C to Part 718. The newly submitted ABGs do not produce values that meet the requirements of the tables found at Appendix C to Part 718. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(ii).

Total disability may also be shown under § 718.204(b)(2)(iii) if the medical evidence indicates that Claimant suffers from cor pulmonale with right-sided congestive heart failure. The record does not contain any evidence indicating that Claimant suffers from cor pulmonale with right-sided congestive heart failure. Therefore, I find that Claimant has failed to establish the existence of total disability under subsection (b)(2)(iii).

Section 718.204(b)(2)(iv) provides for a finding of total disability if a physician, exercising reasoned medical judgment based on medically acceptable clinical or laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevented the miner from engaging in his usual coal mine employment or comparable gainful employment. Claimant's usual coal mine employment as a safety manager included sitting for 2-3 hours per day, standing for four to five hours per day, crawling up to one hour per day, and carrying 10-15 pounds 1000 feet while standing or walking. (DX 7).

The exertional requirements of the claimant's usual coal mine employment must be compared with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000). Once it is demonstrated that the miner is unable to perform his usual coal mine work, a *prima facie* finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(b)(1). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988). Nonrespiratory and nonpulmonary impairments have no bearing on establishing total disability due to pneumoconiosis. § 718.204(a); *Jewell Smokeless Coal Corp. v. Street*, 42 F.3d 241 (1994). All evidence relevant to the question of total disability due to pneumoconiosis is to be weighed, with the claimant bearing

the burden of establishing by a preponderance of the evidence the existence of this element. *Mazgaj v. Valley Camp Coal Co.*, 9 B.L.R. 1-201 (1986).

The newly submitted medical narrative evidence includes reports from four physicians addressing the issue of total disability. Dr. Smiddy submitted a letter and two treatment reports. Noting multiple concomitant underlying health problems, Dr. Smiddy concluded that Claimant's pulmonary impairment was of a sufficient degree to be disabling in and of itself. He based his opinion on at least two physical examinations, a PFT that demonstrated a profound restrictive defect and a severe obstructive lung disease, and Claimant's employment history. I find that Dr. Smiddy's opinion is well-reasoned and well-documented, and therefore, bolstered by his credentials as an internist, and his status as Claimant's treating physician, I accord his opinion significant probative weight.

Dr. Baker considered Claimant's employment history, a qualifying PFT, a non-qualifying ABG, and a physical examination, and diagnosed a moderate obstructive defect and mild resting hypoxemia. Dr. Baker opined that due to the resulting moderate impairment, that Claimant was totally disabled from a respiratory standpoint. I find that Dr. Baker opinion is well-reasoned and well-documented, and therefore, I accord his opinion probative weight.

Dr. Rosenberg determined that based on employment history, physical examination, and two qualifying PFTs, that Claimant suffered from a moderate restriction and a severe obstruction. Based on this evidence, Dr. Rosenberg concluded that Claimant was totally disabled from performing his previous coal mine employment. I find that Dr. Rosenberg's opinion is well-reasoned and well-documented, and therefore, bolstered by his credentials as an internist and pulmonologist, I accord his opinion significant probative weight.

Dr. Repsher ultimately stated that he does not believe that was not totally disabled from a respiratory impairment. Despite his credentials as an internist and pulmonologist, and his review of the extensive record in this claim, I find his medical narrative opinion to be fatally flawed. First, he invalidated the two most recent PFTs of record, finding that they were not interpretable due to poor effort and cooperation. The actual PFT reports, however, stated that cooperation and effort were good. Dr. Repsher ignored these qualifying test results without an explanation as to why he disagreed with the recorded cooperation and understanding levels. Second, Dr. Repsher stated that Claimant's post 1987 job was a desk job, and that this was practically the same work he had done for the 10 years prior to 1987. The record, however, demonstrates that Claimant's pre-1987 position included a significantly higher level of physical exertion than his post-1987 position, and was by no means an office job. In *Worhach v. Director, OWCP*, 17 B.L.R. 1-105 (1993), the Board determined that it was proper for an ALJ to discredit a medical opinion based on an inaccurate length of coal mine employment. While Dr. Repsher's error did not concern length of coal mine employment, I find that failure to consider accurate exertional requirements to be equally detrimental to the weight accorded a physician's opinion. Therefore, I find that while Dr. Repsher based his opinion on objective evidence, the evidence he considered was not accurate, and therefore, his opinion is not well-reasoned.

The newly submitted narrative evidence includes reasoned reports by three physicians, all finding Claimant to be totally disabled from a respiratory or pulmonary standpoint. Therefore, I find that Claimant has proven total disability by a preponderance of the evidence under subsection (b)(2)(iv).

Considering the newly submitted evidence, Claimant has establish that he is totally disabled under both subsections (b)(2)(i) and (b)(2)(iv). Therefore, after weighing all the newly submitted evidence of total disability under §718.204(b), I find that Claimant has satisfied this element of entitlement.

I also find that the newly submitted evidence is "qualitatively" different from the previously submitted medical evidence. First, of the five PFTs prior to 2001, only one reflected qualifying values, as compared to five of seven in the newly submitted evidence. Second, Dr. Rosenberg testified that Claimant's pulmonary function has deteriorated markedly over the last couple of years. (EX 2: 30). I have accorded Dr. Rosenberg's opinion significant probative weight based on his exceptional credentials. As a result, I find that Claimant has demonstrated that he is totally disabled, which constitutes a material change in conditions as required under §725.309 (d). Therefore, Claimants subsequent claim will not be denied on the basis of the prior denial, and thus, in order to receive benefits, he must satisfy the remaining requirements of §718, considering both the old and new evidence.

## PREVIOUSLY SUBMITTED MEDICAL EVIDENCE

I incorporate by reference, as if fully set forth herein, the summaries of the medical narrative reports and hospital treatment records contained in the May 4, 1989 decision and order denying benefits issued by Administrative Law Judge McCarthy. The Claimant has not disagreed with the factual summaries provided by Judge McCarthy, but argues that the newly submitted evidence supports a finding of a material change in condition. Therefore, I will not disturb the factual descriptions of the original evidence, but will refer to it as necessary to resolve the subsequent claim issue now before me.

Since Claimant did not appeal his second claim for benefits under the Act to the Office of Administrative Law Judges, there is no summary of the medical records submitted between 1989 and his filing of the instant claim in 2001. Thus, the undersigned will now summarize these reports, along with all of the previously submitted PFT and ABG evidence of record.

X-RAYS[32]

| Exhibit | Date of X-ray | Date of Reading | Physician / Credentials | Interpretation |
|---|---|---|---|---|
| DX 2 | 1/20/95 | 1/25/95 | Navani, B-reader | 0/1 qq |
| DX 2 | 1/20/95 | 1/20/95 | Kanwai | 0/1 |
| DX 2 | 1/20/95 | 6/19/95 | Barrett, BCR, B-reader | Negative |
| DX 2 | 1/20/95 | 2/13/95 | Sargent, BCR, B-reader | Negative |

PULMONARY FUNCTION TESTS

| Exhibit/ Date | Co-op./ Undst./ Tracings | Age/ Height | $FEV_1$ | FVC | MVV | $FEV_1$/ FVC | Qualifying Results |
|---|---|---|---|---|---|---|---|
| DX 1 3/7/85 | Good/ Good/ Yes | 59 68” | 2.19 | 2.51 | 124 | 87.25 | No |
| DX 1 3/13/87 | Not listed/ Not listed/ Yes | 61 67” | 2.18 | 3.06 | 109 | 71.24 | No |
| DX 1 7/31/87 | Good effort/ Yes | 62 68” | 2.21 | 3.0 | 115 | 73.67 | No |
| DX 1 4/11/88 | Good effort/ Yes | 62 68” | 2.37 | 3.02 | ---- | 78.48 | No |
| DX 2 1/20/95 | Good/ Good/ Yes | 69 66” | **1.29** | **1.29** | **66** | 100 | **Yes**[33] |

All values pre-bronchodilator

ARTERIAL BLOOD GAS STUDIES

| Exhibit | Date | $pCO_2$ | $pO_2$ | Qualifying |
|---|---|---|---|---|
| DX 1 | 3/07/85 | 37.5 | 52 | Yes |
| DX 1 | 3/13/87 | 37.4 | 84 | No |
| DX 1 | 7/31/87 | 41.3 | 71.6 | No |

[32] Judge McCarthy’s 1989 decision and order explained that there were 75 interpretations of 13 different x-ray taken between April 1977 and October 1987, 64 of which were negative for pneumoconiosis. Pneumoconiosis is defined as a latent and progressive disease, it is proper to give greater probative weight to the most recent chest x-rays. *Clark v. Karst-Robbins Coal Co.,* 12 B.L.R. 1-149 (1989)(en banc). As the oldest of the newly submitted chest x-rays is nearly 14 years more recent than any of the chest films considered by Judge McCarthy, and considering the fact that I have reviewed each of these x-ray interpretations, I find that it is not necessary to reproduce the entire list in order to reach a conclusion as to the existence of pneumoconiosis under §718.202(a)(1).

[33] This PFT was validated by Dr. Kramer on June 5, 1995.

| | | | | |
|---|---|---|---|---|
| DX 2 | 1/20/95 | 28.4<br>38.5* | 65.5*<br>72.2 | Yes[34]<br>No |

* Indicates post-exercise values

Narrative Reports

Dr. Kanwai submitted an examination report dated January 20, 1995. (DX 2). Dr. Kanwai considered the following: symptomatology (sputum, wheezing, dyspnea, cough, and orthopnea), employment history (41 years coal mine employment, quitting in 1987), individual history (attacks of wheezing, chronic bronchitis, and high blood pressure), family history (high blood pressure, heart disease, and cancer), smoking history (40 pack-years, quitting in 1985), physical examination (illegible), chest x-ray (0/1), PFT (compatible with obstructive and restrictive pulmonary disease), and an ABG (hypoxemia). Dr. Kanwai diagnosed COPD caused by coal dust exposure and smoking. He opined that Claimant's pulmonary impairment was 70 to 80% due to coal dust exposure and 20 to 30% due to smoking, and as a result, Claimant cannot do any more mine work and cannot go underground.

On June 23, 1995, the Director sent Dr. Kanwai a questionnaire requesting clarification of his opinion. (DX 2). Dr. Kanwai's July 18, 1995 response state that Claimant has CWP and is disabled from his lung condition and not able to engage in his coal mining job.

Pneumoconiosis

Claimant has the burden of proving the existence of pneumoconiosis, as well as every element of entitlement, by a preponderance of the evidence. *See Director, OWCP v. Greenwich Collieries*, 512 U.S. 267 (1994).

Pneumoconiosis is defined by the regulations:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical" pneumoconiosis and statutory, or "legal" pneumoconiosis.
>
> (1) *Clinical Pneumoconiosis*. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconiosis, i.e., conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

[34] This ABG was validated by Dr. Burki on March 14, 1995.

(2) *Legal Pneumoconiosis*. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For the purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

Sections 718.201(a-c).

Section 718.202(a) sets forth four methods for determining the existence of pneumoconiosis.

**(1)** Under § 718.202(a)(1), a finding that pneumoconiosis exists may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). I may also assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 B.L.R. 1-6 (1988); *Clark*, 12 B.L.R. 1-149 (1989).

In Judge McCarthy's 1989 decision and order, he found that an overwhelming majority of the better qualified B-readers found no evidence of pneumoconiosis, with 64 of the 75 interpretations submitted prior to October 1987 determined to be negative. Based on this, he concluded that the Claimant had not satisfied his burden under subsection (a)(1). Upon review of this evidence, I concur with Judge McCarthy's finding.

The x-ray evidence since 1995 includes 13 interpretations of 5 chest x-rays, and one quality-only reading. Dr. Navani, a B-reader, and Dr. Kanwai interpreted the January 20, 1995 film as positive. Drs Barrett and Sargent, both radiologists and B-readers, read the film as negative. Based on dually certified readings by Drs. Barrett and Sargent, I find that the January 20, 1995 chest x-ray is negative for pneumoconiosis.

Dr. Baker interpreted the July 25, 2001 film as positive. Dr. Wiot, a radiologist and B-reader, read the film as negative. Based on dually certified reading by Dr. Wiot, I find that the July 25, 2001 chest x-ray is negative for pneumoconiosis.

Dr. Ahmed and Dr. Alexander, both radiologists and B-readers, interpreted the January 30, 2002 film as positive. Dr. Wiot, read the film as negative. Based on these equally credentialed readings, I find that the January 30, 2002 film is inconclusive.

Dr. Westerfield, a radiologist and B-reader, interpreted the July 8, 2003 chest x-ray as positive for pneumoconiosis. There were no negative readings. Therefore, I find that the July 8, 2003 chest x-ray is positive for pneumoconiosis.

Dr. Rosenberg, a B-reader, and Dr. Alexander read the February 17, 2004 film as positive for pneumoconiosis. Dr. Wiot read the film as negative. Based on the equally credentialed interpretations by Drs. Alexander and Wiot, I find that the February 17, 2004 film is inconclusive.

I find that a six year gap between x-ray evidence is significant. Therefore, considering all of the x-ray evidence together, I find that the 75 x-ray interpretations of films created prior to 1987, and the four readings of the 1995 film are entitled to substantially less weight than those from 2001 through 2004.

I have found that the July 25, 2001 film is positive for pneumoconiosis, the July 8, 2003 film is negative, and the January 30, 2002, and February 17, 2004 films are inconclusive. Furthermore, of the seven dually certified physicians to review these x-rays, three found them to be negative and four found them to be positive for the disease. Therefore, I find that the preponderance of the x-ray evidence, considered together under subsection (a)(1), is equally balanced, and thus, fails to establish the existence of pneumoconiosis.

**(2)** Under § 718.202(a)(2), a determination that pneumoconiosis is present may be based, in the case of a living miner, upon biopsy evidence. While Dr. Caffrey's biopsy report identified anthracitic pigment, he noted that there were no CWP lesions present. In addition, Dr. Caffrey stated that the biopsy of the right upper lobe definitely showed no findings of CWP. Since there is no evidence to contradict his conclusion, and noting Dr. Caffrey's credentials as a Board certified pathologist, I find that Claimant has failed to establish the existence of pneumoconiosis through biopsy evidence under subsection (a)(2).

**(3)** Section 718.202(a)(3) provides that pneumoconiosis may be established if any one of several cited presumptions are found to be applicable. In this case, the presumption of § 718.304 does not apply because there is no evidence in the record of complicated pneumoconiosis. Section 718.305 is not applicable to claims filed after January 1, 1982. Finally, the presumption of § 718.306 is applicable only in a survivor's claim filed prior to June 30, 1982. Therefore, Claimant cannot establish pneumoconiosis under subsection (a)(3).

**(4)** The fourth and final way in which it is possible to establish the existence of pneumoconiosis under § 718.202 set forth in subsection (a)(4) which provides in pertinent part:

> A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers or suffered from pneumoconiosis as defined in § 718.201. Any such finding shall be based on electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. Such a finding shall be supported by a reasoned medical opinion.

§ 718.202(a)(4).

This section requires a weighing of all relevant medical evidence to ascertain whether or not the claimant has established the presence of pneumoconiosis by a preponderance of the evidence. Any finding of pneumoconiosis under § 718.202(a)(4) must be based upon objective medical evidence and also be supported by a reasoned medical opinion. A reasoned opinion is one which contains underlying documentation adequate to support the physician's conclusions. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). Proper documentation exists where the physician sets forth the clinical findings, observations, facts, and other data on which he bases his diagnosis. *Oggero v. Director, OWCP*, 7 B.L.R. 1-860 (1985). On the other hand, an unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d (8th Cir. 1985); *Smith v. Eastern Coal Co*., 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.,* 4 B.L.R. 1-601 (1982). For instance, a medical opinion based upon generalities, rather than specifically focusing upon the miner's condition, may be rejected. *Knizer v. Bethlehem Mines Corp.*, 8 B.L.R. 1-5 (1985). Further, a medical report may be rejected as unreasonable where the physician fails to explain how his findings support his diagnosis. *See Oggero*, 7 B.L.R. 1-860.

A medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. *Gillespie v. Badger Coal Co.*, 7 B.L.R. 1-839 (1985). *See also Bates v. Director, OWCP*, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); *Kendrick v. Kentland-Elkhorn Coal Co.*, 5 B.L.R. 1-730 (1983). In this claim, the previously submitted evidence includes a number of reports both in support and opposed to the existence of pneumoconiosis, these reports are all more than seven years older than the most remote of the newly submitted reports. Therefore, while the evidence contained in the pre-2001 reports may be probative, due to its remoteness, and the progressive nature of pneumoconiosis, I accord it less weight than the newly submitted evidence for the purpose of determining whether Claimant suffers from pneumoconiosis under subsection (a)(4).

The newly submitted evidentiary record contains only five physician opinions that address the existence of pneumoconiosis. Dr. Baker examined Claimant and diagnosed CWP based on the x-ray and coal dust exposure; COPD with a moderate obstructive defect based on the PFT values; and hypoxemia based on the ABG study. Dr. Baker attributed the CWP solely to coal dust exposure, and the COPD and hypoxemia to a combination of coal dust exposure and cigarette smoking. I find that Dr. Baker's CWP conclusion cannot be considered under subsection (a)(4), as it merely amounts to a restatement of the x-ray reading. *Cornett v. Benham Coal, Inc*., 227 F.3d 569 (6th Cir. 2000); *see, also, Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc*., 12 B.L.R. 1-111, 1-113 (1989)(it is permissible to discredit the opinion of a physician which amounts to no more than a restatement of the x-ray reading). Also, while the PFT he considered was qualifying under DOL guidelines, Dr. Baker provided no explanation as to why he found both exposure to coal dust and smoking to be the cause of Claimant's COPD. Likewise, he also provided no explanation as to why cigarette smoking was not the sole cause of the hypoxemia he diagnosed based on the non-

qualifying ABG study. As a result, while Dr. Baker's COPD and hypoxemia conclusions are supported by the objective evidence of record, his failure to provide support for attributing these conditions to coal dust exposure, undermines his finding of legal pneumoconiosis. Therefore, I find his opinion as to clinical pneumoconiosis inapplicable to the analysis under subsection (a)(4), and accord his findings of legal pneumoconiosis little weight.

Dr. Smiddy, an internist, found Claimant to suffer from CWP, COPD, and bronchitis based on coal mine employment, smoking history, two physical examinations, a qualifying PFT, and an x-ray. While Dr. Smiddy's COPD and bronchitis conclusions were well-documented and well-reasoned, at no point in his reports does he attribute these conditions to coal dust exposure, thus, I find he has not diagnosed legal pneumoconiosis. As to clinical pneumoconiosis, in both of his treatment report and in his letter he diagnosed CWP based on the objective evidence of record. However, as Dr. Smiddy did not explain how the results of the physical examinations and PFT values alone support a finding of CWP, but explicitly noted that the x-rays revealed the disease, I find that his report relies on too many generalities. *Knizer*, 8 B.L.R. 1-5. Therefore, despite his credential and status as Claimant's treating physician, I find Dr. Smiddy's opinion as to legal pneumoconiosis is entitled to little weight.

Dr. Wiot, a radiologist and B-reader submitted a CT scan report. Since only the mediastanial windows were submitted, Dr. Wiot did not find it possible to interpret the presence of pneumoconiosis. Therefore, I find this CT scan report is of no value in determining the existence of pneumoconiosis under subsection (a)(4).

Dr. Repsher, and internist, pulmonologist, and B-reader, performed a medical evidence review and concluded that Claimant did not suffer from any type of pneumoconiosis. Concerning his review of the x-ray evidence, I have previously determined his opinions inadmissible due to his consideration of a film reading in excess of the limitations of §725.414. However, aside from the x-ray evidence, Dr. Repsher also considered Claimant's exposure to coal dust, smoking history, and a majority of the newly submitted medical reports, including PFT, ABG, and physical examination evidence. While Dr. Repsher diagnosed COPD and pulmonary emphysema, he opined that there was no x-ray, history, PFT, or ABG evidence to support a finding of CWP. In addition, he noted that the restrictive component of Claimant's PFT results was due to abnormalities resulting from postoperative complications from the previous CABG procedure. He also explained that the obstructive component of the PFT was due to smoking because, based on the medical literature, the "overwhelming probability" is that any detectable COPD would be the result of cigarette smoking or asthma, and it is "very unlikely" that coal dust would be the cause of this condition. By relying on the "probabilities," Dr. Repsher has failed to specifically focus upon the miner's condition, but has instead based his opinion on generalities. *Knizer*, 8 B.L.R. 1-5. Furthermore, as noted above, Dr. Repsher found the most recent PFTs invalid by contradicting the cooperation and understanding determinations of the administering physicians, without explanation. Thus, I find that any conclusion he reaches based on the PFT evidence to be less credible. Therefore, despite Dr. Repsher's exceptional credentials and the objective evidence he considered to reach his opinions as to the existence of pneumoconiosis, I find that his conclusions are unreasoned due to the fact that his opinion was based on generalities and the fact that he apparently modified the findings of the primary physicians who collected the objective data, without explanation.

Dr. Rosenberg, an internist, pulmonologist, and B-reader, determined that Claimant suffered from smoking induced severe pulmonary obstruction, and a non-coal mine induced pulmonary restriction due to linear and pleural abnormalities identified by x-ray. The basis for Dr. Rosenberg's opinions were two physical examinations, an x-ray, Claimant's smoking and employment history, two PFTs, an ABG, and a large amount of the evidence from the instant and previous claims. Concerning the x-rays, Dr. Rosenberg explained that the linear basilar changes and pleural abnormalities he found on the x-ray were not the micronodularity that is found with CWP, and were located in the lower, not the upper lobes, as is typical for CWP. Also, while Dr. Rosenberg was not able to provide an etiology for these liner changes or pleural abnormalities, he emphatically expressed that they were not caused by coal dust exposure. Concerning the ABG studies, Dr. Rosenberg explained that Claimant's diffusion capacity was normal when corrected for lung volumes. Also, concerning the physical examinations, Dr. Rosenberg opined that there was an absence of rales on auscultation, which is a symptom of the micronodularity associated with coal dust exposure. Finally, concerning the PFT evidence, based on the values of the tests and the specific facts of Claimant's dust exposure history, in conjunction with the medical literature, Dr Rosenberg concluded that the severe obstructive component was due to cigarette smoking and not coal dust exposure. He also opined that the restrictive component of the PFT was the result of the linear type disease seen on the chest x-ray. I find that Dr. Rosenberg has relied on the objective evidence of record to support his conclusion that Claimant does not suffer from clinical or legal pneumoconiosis. He has also provided a very detailed explanation, specific to the Claimant, as to why he does not believe that the total pulmonary disability was caused by exposure to coal dust. Therefore, I find that Dr. Rosenberg's well-reasoned and well-documented opinions, bolstered by his superior credentials, are entitled to substantial probative weight.

I have accorded little weight to Dr. Baker's and Dr. Smiddy's opinions concerning pneumoconiosis, and substantial probative weight to Dr. Rosenberg's well-reasoned opinion. And while I have reviewed all of the evidence of record, due to the progressive nature of pneumoconiosis, I have accorded more weight to the newly submitted evidence. Therefore, I find that the preponderance of the newly submitted evidence under subsection (a)(4) does not support a finding of clinical or legal pneumoconiosis.

Reviewing the evidence considered under § 718.202(a) as a whole, I find that Claimant has not established that he suffers from pneumoconiosis pursuant to subsection (a)(1-4). Therefore, considering all of the newly submitted and prior medical evidence, I find that Claimant has failed to prove that he suffers from pneumoconiosis under § 718.202 (a) by a preponderance of the evidence.

Total Disability Due to Pneumoconiosis

The amended regulations at § 718.204(c) contain the standard for determining whether Miner's total disability was caused by Miner's pneumoconiosis. Section 718.204(c)(1) determines that a miner is totally disabled due to pneumoconiosis if pneumoconiosis, as defined in § 718.201, is a "substantially contributing cause" of the miner's totally disabling respiratory or pulmonary impairment. Pneumoconiosis is a "substantially contributing cause" of the miner's disability if it has a material adverse effect on the miner's respiratory or pulmonary condition or

if it materially worsens a totally disabling respiratory or pulmonary impairment which is caused by a disease or exposure unrelated to coal mine employment. §§ 718.204(c)(1)(i) and (ii). Section 718.204(c)(2) states that, except as provided in § 718.305 and § 718.204(b)(2)(iii), proof that the Miner suffered from a totally disabling respiratory or pulmonary impairment as defined by §§ 718.204(b)(2)(i), (ii), (iv), and (d) shall not, by itself, be sufficient to establish that the miner's impairment was due to pneumoconiosis.

Except as provided by § 718.204(d), the cause or causes of a miner's total disability shall be established by means of a physician's documented and reasoned medical report. § 718.204(c)(2). The Sixth Circuit Court of Appeals has stated that pneumoconiosis must be more than a "de minimus or infinitesimal contribution" to the miner's total disability. *Peabody Coal Co. v. Smith,* 12 F. 3d 504, 506-507 (6th Cir. 1997). The Sixth Circuit has also held that a claimant must affirmatively establish only that his totally disabling respiratory impairment (as found under § 718.204) was due - at least in part – to his pneumoconiosis. *Cf*. 20 C.F.R. 718.203(a); *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1988); *Cross Mountain Coal Co. v. Ward*, 93 F.3d 211, 218 (6th Cir. 1996)(opinion that miner's impairment is due to his combined dust exposure, coal workers pneumoconiosis as well as his cigarette smoking history is sufficient). More recently, in interpreting the amended provision at § 718.204(c), the Sixth Circuit determined that entitlement is not precluded by "the mere fact that a non-coal dust related respiratory disease would have left the miner totally disabled even without exposure to coal dust." *Tennessee Consolidated Coal Co. v. Director, OWCP [Kirk]*, 264 F.3d 602 (6th Cir. 2001). A miner "may nonetheless possess a compensable injury if his pneumoconiosis materially worsens this condition." *Id*.

Claimant has failed to establish by a preponderance of the evidence that he suffers from pneumoconiosis. As discussed above, I have found the reasoned opinions of Dr. Rosenberg to outweigh those presented by Drs. Smiddy and Baker. Therefore, based on the weight of Dr. Rosenberg's well-reasoned and well-documented opinion, and bolstered by his credentials as an internist and pulmonologist, I find that Claimant has failed to prove by a preponderance of the evidence that his total disability was caused, in part, by pneumoconiosis.

Entitlement

The Claimant, Mr. West, has establish a material change in conditions sufficient to meet the statutory requirements of § 725.309(d), but has failed to prove that he suffered from pneumoconiosis, or that his was total disability was due pneumoconiosis. Therefore, Mr. West is not entitled to benefits under the Act.

Attorney's Fees

An award of attorney's fees is permitted only in cases in which the claimant is found to be entitled to benefits under the Act. Because benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for the representation and services rendered in pursuit of the claim.

## ORDER

IT IS ORDERED that the claim of Monroe Lee West for benefits under the Act is hereby DENIED.

A

THOMAS F. PHALEN, JR.
Administrative Law Judge

**NOTICE OF APPEAL RIGHTS:** If you are dissatisfied with the administrative law judge's decision, you may file an appeal with the Benefits Review Board ("Board"). To be timely, your appeal must be filed with the Board within thirty (30) days from the date on which the administrative law judge's decision is filed with the district director's office. *See* 20 C.F.R. §§ 725.458 and 725.459. The address of the Board is: Benefits Review Board, U.S. Department of Labor, P.O. Box 37601, Washington, DC 20013-7601. Your appeal is considered filed on the date it is received in the Office of the Clerk of the Board, unless the appeal is sent by mail and the Board determines that the U.S. Postal Service postmark, or other reliable evidence establishing the mailing date, may be used. *See* 20 C.F.R. § 802.207. Once an appeal is filed, all inquiries and correspondence should be directed to the Board.

After receipt of an appeal, the Board will issue a notice to all parties acknowledging receipt of the appeal and advising them as to any further action needed.

At the time you file an appeal with the Board, you must also send a copy of the appeal letter to Donald S. Shire, Associate Solicitor, Black Lung and Longshore Legal Services, U.S. Department of Labor, 200 Constitution Ave., NW, Room N-2117, Washington, DC 20210. *See* 20 C.F.R. § 725.481.

If an appeal is not timely filed with the Board, the administrative law judge's decision becomes the final order of the Secretary of Labor pursuant to 20 C.F.R. § 725.479(a).